Evaluation of State-Funded Problem Gambling Treatment Programs in Nevada

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EXECUTIVE SUMMARY

- An independent research team from the University of Nevada, Las Vegas carried out follow-up evaluation research with clients who had received treatment from problem gambling programs that were fully or partially supported by the state of Nevada in 2006-2007.

- The methodology of this project was informed by the most up-to-date research literature on problem gambling program evaluation, and by consultations with leading experts in state-sponsored problem gambling treatment.

- The research team conducted confidential quantitative telephone interviews with 75 individuals who had received a treatment intervention. The research team also conducted qualitative research with each of the interviewees so that their opinions could be recorded in their own words, rather than in categories pre-determined by the researchers.

- Both the quantitative and the qualitative analyses indicate that interviewees were very pleased with the treatment that they received. The overwhelming majority reported very positive quantitative impressions of the programs, and this finding was reinforced by exceedingly positive qualitative evaluations of their experiences. In addition to these attitudinal measures, behavioral measures indicated profound reductions in gambling behaviors.

- These findings are perhaps especially impressive when viewed in light of the fact that those who seek treatment tend to be the severest of problem gamblers. Furthermore, because this study examined both completers and non-completers of treatment, these findings seem to indicate that even partial interventions can yield significant improvements in wellbeing.

- More concretely, very strong majorities felt that they were able to get all of the services they needed, that they were encouraged to take responsibility for their life, and that they were given the information they needed to take charge of their gambling problem.

- When asked their opinions about the direct results of the services they received, respondents indicated overwhelmingly that their lives had changed for the better. This finding was consistent in both the quantitative and the qualitative analyses conducted for this study.

- Specifically, very strong majorities indicated that as a direct result of the services they received, they dealt more effectively with daily problems, they were better able to control their lives, they dealt more effectively with crises, they got along better with their families, they did better in social situations, they did better in school and/or work, their housing situation had improved, their symptoms were no longer as

bothersome, their financial situation improved, they spent less time thinking about gambling, and they had re-established important relationships in their lives. Clearly, respondents felt that these programs had profound and powerful effects on their material, emotional, social, and psychological wellbeing.

- Interestingly, chemical and behavioral addictions were also dramatically reduced among many who participated in the survey. While preliminary, this finding suggests that the mental health improvements observed extend beyond the narrow range of problems associated with gambling, and that these services may well help address the complex constellation of co-morbid and/or addictive issues that individuals with gambling problems face.

- About one-third of participants admitted to gambling during treatment or since completing treatment. The qualitative research conducted for this report revealed that "slips" tended to be short-lived, and that virtually all of those who had "slipped" tended to blame themselves and not the treatment process.

- Overall, respondents reported substantial reductions in their gambling – measured both in terms of time played and money spent while gambling. A very strong majority indicated that they were currently abstinent from gambling, with a large number reporting that they had abstained from gambling for six months or longer. As the research literature suggests that abstinence is a strong measure of success, it would seem that this finding provides additional evidence of the positive effects of these programs.

- When asked about shortcomings, respondents were concerned about a lack of legal assistance (including bankruptcy advice), loan and debt programs, aftercare counseling programs (for gambling and for other needs), and one-on-one counseling. Ultimately, the biggest criticism articulated in both the quantitative and qualitative analyses was that respondents indicated that they wanted *more* services. Notably, with additional funding and/or a redistribution of funds, these needs can be better addressed in the future.

- Many also suggested that treatment providers would benefit from a greater knowledge of a diverse range of treatment skills. Hence, in order to provide more and better treatment for the state's problem gamblers, we recommend that the state continues its commitment to educating those who help problem gamblers and their families.

- We also recommend more generally that the state continue its commitments to the state's problem gamblers and their families, and that it continues to conduct independent research on the efficacy of these commitments.

PREFACE

Recent overviews (Shaffer, Hall, & Vander Bilt, 1999; National Research Council, 1999; Volberg, 2001) indicate that problem gambling is a robust phenomenon that occurs in a wide variety of settings. Certainly, Nevada is no exception (Volberg, 2002), and the state has recently responded to calls for a public health approach to pathological gambling (Korn & Shaffer, 1999) by funding a variety of programs aimed at helping those with gambling-related problems.

This project provides research-based insights on the effectiveness of the problem gambling treatment programs that were fully or partially funded by the state of Nevada through a series of grants distributed in 2006-2007. To measure effectiveness, we rely upon the most recent advances in the peer-reviewed academic literature, as well as the input from a variety of local and national experts on program evaluation.

INTRODUCTION AND LITERATURE REVIEW

This research is informed by insights derived from two primary resources: 1) the scientific, peer-reviewed literature on evaluating outcomes in problem gambling treatment, and 2) a state-specific framework suggested by the leading experts in state-supported problem gambling treatment evaluation. In our view, both of these resources provide vital perspectives on this challenging endeavor. The former approach ensures that this research is grounded in the scientific literature, and the latter ensures that the project meets the unique needs associated with US-based government-supported treatment programs. This approach – one grounded in the best global science, but cognizant of local nuance – is particularly important when attempting to research a behavioral phenomenon as complex as pathological gambling and its treatment (Bernhard, forthcoming).

For years, one of the major challenges in the pathological gambling research area was a lack of consensus on the best method of evaluating the success of treatment programs. The past two years, however, have seen this oft-cited shortcoming addressed in an impressive fashion. In particular, two major developments have helped push this research field forward.

The first development was the devotion of a special 2005 issue of the *Journal of Gambling Studies* to this very topic. This special issue included a number of review articles in addition to primary research pieces written by several of the leading experts in the problem gambling research field. The second development was the "Banff Consensus," which developed out of an academic research conference in Alberta that convened key experts in the area (many of whom also participated in the *JGS* special issue). Both of these pioneering contributions have informed this research in important ways, as we will discuss in the rest of this section.

Journal of Gambling Studies Special Issue (2005)

The special 2005 issue of *JGS* highlights a number of important methodological challenges associated with evaluating the success of problem gambling treatment interventions. In the following section, we highlight the key methodological issues discussed in this special issue, and then we describe how they were addressed in this research.

- As Blaszczynski (2005) notes, high rates of attrition are quite common when attempting to follow up with problem gamblers. To this, we wish to add that very often problem gamblers have an incentive *not* to be found during follow-up. Problem gamblers may add researchers to a list of others such as debtors who wish to follow up in a less than friendly way. ***In our research, we attempted to increase our response rates by contacting individuals at various times of the day, contacting individuals during weekdays and on weekends, and clearly identifying ourselves as independent researchers conducting a confidential study. Our response rate of 74.3%[1] falls above the cited rates of 50-60%.***

- As is the case with most addictive disorders, abstinence is the most common goal for those administering and receiving treatment for pathological gambling (Echeburua & Baez, 1994). In fact, in their review article, Echeburua and Fernandez-Montalvo go so far as to claim that "currently, there is no empirical support for the idea that responsible gambling can be a goal in the treatment of pathological gamblers" (2005, p. 21). While many reputable clinical experts maintain that responsible gambling might serve as a reasonable objective for some gamblers, at the very least, abstinence should serve as a vital component of any treatment outcome evaluation. ***Hence, in our research, we asked questions that directly targeted the amount of abstinence that research subjects had achieved at the time of the interview.***

[1] This rate is calculated based upon those who agreed to be contacted and who provided working telephone numbers. We discuss this calculation in greater detail later in the report.

- Building upon the previous point, Gamblers Anonymous advocates an abstinence model. Petry (2005) also notes that preliminary evidence shows that Gamblers Anonymous (GA) attendance in conjunction with professional treatment is associated with higher success rates. However, Petry also points out that the research in this area is limited and could be improved. ***Because of this preliminary evidence and the ubiquity of Gamblers Anonymous in Nevada, we sought to gather data that measured the degree to which this was integrated into the treatment process.***

- As is always the case when researching pathological gambling, the complex contribution of co-morbid disorders needs to be addressed (National Research Council, 1999; Shaffer, Hall, & Vander Bilt 1999). As several researchers note (see., e.g., Blaszczynski, 2005; Nathan 2005), this issue is rarely engaged in problem gambling outcome research. ***To address this shortcoming, Blaszczynski suggests that studies include information on the co-morbid issues that the research subjects confront, the socio-demographic backgrounds of the subjects, and the different forms of gambling that the subjects engaged in. All of these suggestions were integrated into this research.***

- The research team also wanted to be sensitive to the reality that problem gamblers are often involved in a variety of different professional and nonprofessional interventions. For instance, over time a problem gambler may be prescribed an antidepressant, asked to attend Gamblers Anonymous meetings, urged by their children to give up gambling, forced by a spouse to participate in marital counseling, admitted to a hospital after a suicide attempt, referred to a homeless service provider upon getting kicked out of the home, and so on. As el-Guebaly (2005) points out, any of these could contribute to the improvement in the wellbeing of the problem gambler. ***In our study, we address this important consideration by asking about a variety of other interventions that a pathological gambler might have engaged, including housing aid, financial***

services, medical assistance, homeless assistance, Veterans' assistance, and a handful of other resources.

- A reasonable question that arises whenever research relies upon self-reported information pertains to whether we can trust the information obtained in this manner. This concern is perhaps especially important when examining gambling data, which can be plagued by poor recall (Blaszczynski et al. 1997). However, the research that has been conducted in this area indicates that self-reports from gamblers who participate in treatment studies tend to agree reasonably well with reports obtained from family, friends, or other "collateral" reports (Echeburua *et al.* 1996, Hodgins & Makarchuk 2003), a finding that is also noted in the Banff Consensus article. ***In our research, we rely upon self-report data, an approach that is supported by previous research findings. However, in the future, when more time and resources can be devoted to researching treatment efficacy in Nevada, it would be prudent to attempt to complement self-report data with collateral report data.***

- Finally, it should also be noted that those with the most severe problems tend to seek out treatment, while those with less severe cases tend not to seek treatment (Hodgins, 2005, Klingemann et al., 2001). ***Hence, because treatment programs appear to engage those who suffer from the severest forms of problem/ pathological gambling, treatment outcomes research should be interpreted with this in mind.***

The Banff Consensus (2006)

In one dramatic stroke, a 2006 article (published in the prestigious academic journal *Addiction* by Walker, et al.*)* convened leading researchers to provide recommendations based upon the best and most current knowledge on pathological gambling treatment evaluation.

The Banff Consensus recommends the measurement of three key elements in evaluating the effectiveness of treatment interventions with pathological gambling. These three elements are: 1) reduction in gambling behaviors, 2) reduction in the problems caused by gambling behaviors, and 3) a determination that changes observed are a direct result of the therapy's hypothesized mode of action.

Following this consensus, the research team for this project developed an instrument that examines all three of these important areas. In the next section, we will discuss how each area was operationalized in this research.

1) Reduction in Gambling Behaviors. As the Banff Consensus indicates, "any single measure of involvement is unlikely to capture all of the aspects of gambling relevant to gambling-related problems" (Walker *et al.*, 2006, p. 505). Hence, it is important to ask a series of questions about gambling behaviors to assess any changes that have taken place. ***In this report, we follow the recommendations of the Banff Consensus by measuring changes that pertain to both time and money.***

This research examines both types of time-oriented changes that are recommended by the Banff Consensus: changes in time spent gambling, and changes in time spent thinking about gambling. The former represents an absolute measure in the amount of time spent engaged in gambling activity, and the latter gets at the important diagnostic matter of preoccupation with gambling. Preoccupation is listed in the Diagnostic and Statistical Manual of Mental Disorders (4th ed., text revision, American Psychiatric Association, 2000) as a key criterion in determining whether an

individual suffers from pathological gambling. Our questionnaire also included questions about changes in the amount of money wagered during gambling activity. These questions focused on reductions in the amount of money spent (that is, the net amount of money lost) over time.

2) Reduction in the Problems Caused by Gambling Behaviors. Research on the reduction of problems caused by gambling behaviors is relatively underdeveloped in the problem gambling field. As such, the Banff Consensus recommends that until the research literature arrives at a conclusion on a gold standard measure of the problems associated with gambling, researchers should "select an appropriate standardized measure from those currently available in reporting outcomes."

The current research followed this recommendation, and after receiving input from the leading experts in state-sponsored problem gambling treatment evaluation, we have selected the MQR (short for Mental Health Statistics Improvement Program Quality Report, to be discussed in greater detail in the next section) as a standardized measure. Among other things, this instrument measures changes in everyday life functioning, family relationships, social relationships, work functioning, housing situations, and financial situations.

3) Determination that Changes Observed Are a Direct Result of the Therapy's Hypothesized Mode of Action. This somewhat wordy description can be simplified to a relatively straightforward research question: did the therapy work in the way that it claims to work? To illustrate, we would expect that therapies that target behavioral change should be able to demonstrate efficacy in that area as a direct result of the therapies offered. ***In our case, the research team was careful to ask the research subjects whether certain behavioral and cognitive (thinking) changes took place "as a direct result of services (they) received." Although this report is not intended to compare different treatment approaches (but rather to evaluate all treatment programs funded by the state), we are able to offer some preliminary assessments that address this key issue.***

State-specific Frameworks

The research team also contacted leading experts in state-sponsored treatment evaluation to inquire as to what kinds of evaluation measures are currently used in other jurisdictions. This approach allowed us to build upon the experiences and knowledge in other jurisdictions, and it also allowed us to develop a database that can ultimately be used to compare findings across states.

To learn more about other states' evaluations, we consulted Tim Christenson, chief treatment administrator for the state of Arizona's Office of Problem Gambling, and Jeffrey Marotta, Ph.D., who serves as problem gambling services manager for the widely-hailed problem gambling program offered by the state of Oregon Department of Human Services. Mr. Christenson also serves as the current president of the Association of Problem Gambling Service Administrators (APGSA), and Dr. Marotta serves as the current vice president.

Discussions with these experts led the research team to implement an instrument developed by the Mental Health Statistics Improvement Program (MHSIP). The MHSIP relied upon a collaboration of a vast array of mental health organizations to develop a set of measures called the MHSIP Quality Report (MQR). This coalition convened an impressive array of stakeholder organizations to improve upon existing performance measures, and to develop a standardized series of questions that effectively measure mental health outcomes. The organizations that contributed to this instrument's development include the American Managed Behavioral Healthcare Association, the American College of Mental Health Administration, the National Alliance for the Mentally Ill, the National Mental Health Association, the Federation of Families, the National Association of State Mental Health Program Directors, the National Association of State Mental Health Program Directors Research Institute, the National Council of Community Behavioral Healthcare, the National Association of Consumer/Survivor Mental Health Administrators, the National Association of Mental Health Planning and Advisory Councils, state mental health planners, Center for Mental Health Services, and

representatives of the Recovery Measurement Group and the Outcomes Roundtable for Children and Families.

In addition to these groups, an expert review and feedback panel included representatives from a variety of accreditation organizations, including the National Committee on Quality Assurance, the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation, the Council on Quality and Leadership, the Federal Forum on Performance Measures, the developers of the Experience of Care and Health Outcomes Survey, and the Human Services Research Institute. In sum, the MQR instrument represents the cumulative and collaborative effort of an expert coalition of major mental health organizations whose expertise falls under the very sorts of areas that we sought to research in this project.

Another important advantage which was highlighted by the experts we consulted is the fact that this instrument is publicly available and intended for the widest possible use in mental health settings. Moving forward, this questionnaire will be implemented in treatment evaluation settings in both Nebraska and Arizona, allowing for future comparisons of outcomes data. Ultimately, it became clear to this research team that the reasons for using the MQR were quite strong.

More information on the development of the MQR is outlined on the MHSIP's web site:

http://www.mhsip.org/QualityRptandToolkit/MHSIPQualityReport2005.pdf

METHODOLOGY

Sample

The sample of interviewees was taken from a list of clients given to the research team by the treatment providers themselves.[2] Treatment providers were asked to provide the research team with lists of *all* individuals who received problem gambling services – including those who did not complete treatment. All of those who were called for the telephone interview had signed documents indicating that they could be contacted for confidential follow-up research.

Ultimately, the research team was given a list of 101 individuals who were eligible to be contacted and who provided working telephone numbers for us to contact them. Of those, 75 individuals were successfully contacted and completed the interview, for a response rate of 74.3%. This response rate compares very favorably with figures commonly cited in the research literature (according to Blasczcynski 2005, rates generally fall between 50 and 60%). Because not all questions were applicable to all participants (for instance, some indicated that their housing situation was never affected by their gambling), the total number of answers to each question may not add up to 75.

Questionnaire

The final questionnaire (presented in full in Appendix A) represented a combination of items from the MQR, items reflecting the most recent suggestions from the peer-reviewed academic literature, items from the baseline data collection currently in use by all of the treatment providers in the study, and items suggested by members of the State of Nevada Governor's Advisory Committee on Problem Gambling. The full

[2] The data in this report were gathered with interviews of those who had attended The Problem Gambling Center Las Vegas, The Problem Gambling Center Reno, Comprehensive Therapy Centers, and the Salvation Army. It should be noted that some of the other treatment centers – notably Bristlecone – had clients who were in halfway house situations and hence could not be contacted for follow-up.

questionnaire was approved by the UNLV Office for the Protection of Human Subjects (protocol # 0612-2191).

Data Collection

Telephone interviews were conducted by trained interviewers with at least a masters' degree in a social science field. In addition, all interviewers had successfully completed the CITI Course in the Protection of Human Research Subjects, as mandated by the UNLV Office for the Protection of Human Subjects. In order to maximize response rates, subjects were phoned at varying hours of the morning, afternoon, and evening, with additional emphasis placed on weekday evening and weekend calls. All clients who were on the list of those who had consented to be interviewed were contacted repeatedly, and potential interviewees who were never successfully contacted were phoned a minimum of 12 times.

The questionnaire was programmed into a computer-assisted telephone interview program, which allowed for immediate input of data into a password-protected database accessible only to the authors of this report. This kind of direct-entry approach is widely recognized as a best practice, as it ensures that data entry errors are avoided.

Fortunately, on a previous grant this research team was responsible for summarizing intake data from each of these participants, and this current project benefited significantly from the ability to match follow-up responses with those provided by the same individuals while entering treatment.

Informed Consent and Ethical Considerations

All interviewees were read an informed consent statement, and consented verbally to the interview. They were informed that this study was being conducted by the University of Nevada, Las Vegas in order to objectively evaluate the services that they had received. It was further emphasized that the university was not affiliated with the

treatment centers, and had been contracted to conduct an independent evaluation of their services.

Clearly, confidentiality is a prime concern when conducting research of this nature. If clients do not feel that their responses will be kept confidential, they would presumably be less likely to provide honest assessments of the services they received. Interviewees were repeatedly assured (at regular intervals throughout the interview process) that their responses would be kept confidential -- i.e., names and other identifying information would not be used in the final report, they would be identified in the research database solely by an ID number, and that all identifying information would be kept stored in a locked cabinet for seven years, and then destroyed.

Interviewees were further informed that they could refuse to answer any of the questions that were posed to them, and they could terminate their participation at any time. All research methods employed in this project were approved by the UNLV Office for the Protection of Human Subjects (protocol # 0612-2191).

Limitations

All research designs contain limitations that arise prior to, during, and/or after the project is finished, and this project is no exception. Even in the highly systematic world of pharmacological treatment evaluations, methodological limitations abound (for overviews, see Hollander et al., 2005; Potenza 2005). In practice, thoughtful and thorough discussions of limitations help researchers build better projects in the future, and it is in this spirit that we discuss a handful of important issues that need to be considered when contemplating the meanings of this research.

First, this research analyzes a relatively small sample size of 75 respondents. Though this sample size may appear to be relatively small, samples sizes of this size are common in this research area (see Ladouceur & Shaffer, 2005), and useful information can certainly still be garnered from the analyses. However, while this limitation is quite

common, we recommend that in the future every reasonable effort is undertaken to increase the "N" in future evaluations of Nevada's problem gambling treatment services. In addition, our sample was disproportionately male, which may also bias results somewhat.

Another limitation that plagues all evaluations of treatment seekers is the observation that "comparatively few pathological gamblers seek treatment… fewer still participate in treatment outcome studies" (Nathan, 2005). Because of this, it is important to point out that these data should not be interpreted as necessarily representative of the broader population of pathological gamblers -- many of whom choose not to seek treatment. What is more, it appears that those who show up in treatment settings may in fact suffer from more severe forms of gambling disorders (Hodgins, 2005, Klingemann et al., 2001), so care should be taken when interpreting these findings.

In fact, there is a broader "selection bias" inherent in relying upon those who have consented to be interviewed for any research study. For instance, it could be that those who consent are those who feel strongly (positively or negatively) about the treatment experience, and who are enthusiastic about having their voice heard. As a result, we may well miss out on those who are largely indifferent and/or ambivalent about the treatment experience. In any case, without the ability to interview those who did not consent to be interviewed, we cannot know for certain what their responses might be.

As Shaffer et al. note in their study of treatment outcomes in an Iowa problem gambling treatment program, "examining statewide treatment programs is important because these clinical settings provide access to larger sample sizes and more diversity among treatment seekers. However, evaluating these systems is often a compromise between scientific rigor and clinical practicality" (2005, p. 71). Virtually all in the pathological gambling research field agree that the ideal format for this kind of research is one in which control groups (with individuals who do not receive any treatment at all) are examined and compared against those who do receive treatment (see, e.g., Blaszczynski, 2005; Walker, 2005). For many reasons (some of them ethical in nature),

this ideal is not always achieved, but as Shaffer et al note, this does not mean that important lessons are impossible to learn in the absence of "pure science."

Finally, we did not offer any compensation whatsoever for participating in this research, which could actually strengthen the validity of the findings presented here. As Toneatto (2005) points out, financial incentives introduce bias, motivate subjects for the wrong reasons, and provide a stimulus that would not be found in a naturalistic setting in the real world. While Toneatto worries that *not* offering compensation to participants might depress response rates, we did not find a single instance in which subjects refused to participate due to a lack of financial incentive. In any case, the response rate that was achieved with this study was quite strong when compared to other studies in this area.

RESULTS

QUANTITATIVE RESEARCH

In the next section, we summarize the quantitative findings gathered from the telephone interviews. We first present demographic information on the sample, gathered both at intake and during the follow-up study. We then summarize the interviewees' opinions about the quality of the services they received. Next, we present data on participants' opinions about the direct results that they have experienced. We also explore the other types of services sought by the study participants, and present suggestions for other services that should be considered. After asking about comorbidity issues (and specifically multiple addictions), we then conclude by presenting data on the degree to which gambling behaviors were reduced during the study period.

Demographics

The overall age of the sample ranged from 26-82 years, with a mean age of 51 years (sd = 11.9 years). When broken down by gender, female age ranged from 27-73 years with a mean of 52 (sd = 13.5), and male age ranged from 26-82 years with a mean of 50 (sd = 11.3 years).

Overall gender breakdowns revealed that this sample was predominantly male (73% male vs. 27% female). Interestingly, the percentages of males and females in the overall treatment sample do not differ as dramatically, with just over half of participants being male. A full 75% of those who indicated a race/ethnic background were white, with the remainder split fairly evenly among Native American, Asian, African American, Latino, and Pacific Islander categories. Participants in the study had an average of 13.2 years of education (sd = 1.83 years). Of those who indicated a marital status, 49% were divorced, 27% had never been married, and 22% were married.

Out of this sample, 58% respondents reported a past arrest (and of those, 21% are currently on probation), 29% reported that they had spent time in prison, and 12% reported current outstanding charges. This finding emphasizes the oft-cited frequency of legal issues faced by the severest of problem gamblers.

Opinions about Treatment Services

Table 1 summarizes participant opinions about the services they received.

Table 1. Participant Opinions about Services Received

*Frequency and (percentage) are shown

	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
1. I like the services that I received from this service provider.	50 (69)	15 (21)	6 (8)	1 (1)	1 (1)	0 (0)
2. I would recommend this agency to a friend or family member.	62 (85)	10 (14)	1 (1)	0 (0)	0 (0)	0 (0)
3. Services were available at times that were good for me.	47 (64)	14 (19)	6 (8)	6 (8)	0 (0)	0 (0)
4. I was able to get all the services I thought I needed.	42 (58)	17 (23)	7 (10)	4 (6)	2 (3)	1 (1)
5. Staff here believe that I can grow, change and recover.	58 (80)	11 (15)	4 (5)	0 (0)	0 (0)	0 (0)
6. I felt comfortable asking questions about my treatment.	57 (78)	10 (14)	3 (4)	1 (1)	1 (1)	1 (1)
7. Staff encouraged me to take responsibility for how I live my life.	61 (84)	9 (12)	3 (4)	0 (0)	0 (0)	0 (0)
8. Staff were sensitive to my cultural background (race, religion, language, etc.)	46 (63)	12 (16)	3 (4)	1 (1)	0 (0)	11 (15)
9. Staff helped me obtain the information I needed so that I could take charge of managing my gambling problem.	48 (66)	19 (26)	3 (4)	1 (1)	1 (1)	1 (1)
10. I was encouraged to use other appropriate programs (support groups, 12-step groups, crisis phone line, etc.).	63 (86)	7 (10)	1 (1)	1 (1)	0 (0)	1 (1)

This table reveals that the overwhelming majority of participants reported very positive impressions of the programs overall. If the "strongly agree" and "agree"

categories are combined, fully 90% indicate that they liked the services they received, and an even more impressive 99% said that they would recommend their program to friends and/or family members. Very strong majorities also felt that services were accessible and that they were able to receive all of the services that they needed.

In addition, program staff were reported to be professional, appropriate, and helpful: 95% indicated that they believed that staff believed they could recover, 92% felt comfortable asking questions about treatment, and 96% felt encouraged to take personal responsibility for their lives. Staff also scored high on sensitivity to cultural backgrounds (note that we eliminate if the 11 respondents who indicated that this item was not applicable to them, 94% answered in the affirmative). Respondents also overwhelmingly felt that staff provided them with appropriate educational information, and that staff encouraged them to engage other resources such as Gamblers Anonymous. On the latter point, as Petry (2005) points out, simultaneous participation in GA appears to be associated with higher success rates, though the evidence is still somewhat limited.

Opinions about Direct Results of Services

Table 2 summarizes participant opinions about the direct results of the services they received. Note that each item below was prefaced by the statement "As a direct result of services I received…"

Table 2. Participant Opinions about the Direct Results of Services they Received

*Frequency and (percentage) are shown

As a direct result of services I received:	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
1. I deal more effectively with daily problems.	43 (59)	16 (22)	7 (10)	2 (3)	3 (4)	2 (3)
2. I am better able to control my life.	41 (56)	18 (25)	8 (11)	2 (3)	3 (4)	1 (1)
3. I am better able to deal with crisis.	41 (56)	19 (26)	9 (12)	2 (3)	1 (1)	1 (1)
4. I am getting along better with my family.	45 (62)	15 (21)	4 (6)	2 (3)	1 (1)	6 (8)
5. I do better in social situations.	39 (53)	17 (23)	8 (11)	2 (3)	2 (3)	5 (7)
6. I do better in school and/or work.	30 (41)	15 (21)	6 (8)	2 (3)	1 (1)	19 (26)
7. My housing situation has improved.	23 (32)	11 (15)	11 (15)	2 (3)	3 (4)	23 (32)
8. My symptoms are not bothering me as much.	42 (58)	18 (25)	9 (12)	1 (1)	2 (3)	1 (1)
9. My financial situation has improved.	34 (47)	15 (21)	12 (16)	2 (3)	3 (4)	7 (10)
10. I spend less time thinking about gambling.	41 (56)	20 (27)	6 (8)	3 (4)	2 (3)	1 (1)
11. I have re-established important relationships in my life.	37 (51)	16 (22)	8 (11)	1 (1)	2 (3)	9 (12)

Once again, the vast majority of participants reported agreement or strong agreement with each of these items, indicating that as a group this sample was very satisfied with the direct results of these programs. When asked whether they now dealt more effectively with daily problems and crises, more than 8 out of 10 answered in the affirmative. Encouragingly, a similar proportion also indicated that they felt they had more control in their lives as a result of having gone through treatment.

When it came to social environments, respondents indicated that as a direct result of the services received, they were getting along better in both family and in social situations, and strong majorities also indicated that they had re-established important relationships (note that not all respondents indicated that these items were applicable, indicating that for some, this was not troublesome to them prior to entering treatment).

On material matters, an overwhelming proportion of respondents cited improvements in housing, work/school, and financial spheres of their lives. On these items, particularly revealing is when the "not applicable" group is eliminated from the analyses. For instance, when we eliminate the 19 respondents who stated that the work/school item was "not applicable," 83% answered "strongly agree" or "agree" – which seems to indicate that for working (or schooling) Nevadans in this sample, these programs were very successful. Among those who said that the housing item was applicable, a striking 94% answered in the affirmative when asked whether their situation had improved. Finally, among those reporting that their financial situation was relevant, 74% said that it had improved as a direct result of treatment.

When psychological measures were introduced, once again the sample overwhelmingly endorsed positive reviews of the treatment programs. Specifically, more than 8 out of 10 said that their symptoms were no longer bothering them as much, and a similar proportion said that they spent less time thinking about gambling (an item that corresponds with preoccupation, one of the diagnostic criteria for pathological gambling in the DSM-IV-TR) (APA, 2000). Overall, then, it appears that these programs score quite well when measured against the backdrop of the areas suggested by the Banff Consensus (e.g., reduction in the problems associated with gambling, the programs working in the ways that they are hypothesized – in this instance, by addressing some of the cognitive issues that problem gamblers face).

Other Professional Services

The questionnaire also sought information on external services received by this sample, but overall it appears that few participants relied upon professional services other than those offered by these treatment providers. However, those that did rely upon external services tended to seek outside counseling services. When asked about the types of services that they would have *liked* to have seen (but did not see) in these treatment programs, relatively few participants had suggestions for improvement. Those who did

provide suggestions sought additional programs for legal assistance (including bankruptcy), loan and debt counseling, aftercare counseling (both for gambling and for other needs), and one-on-one counseling. This finding seems to provide support for the notion that more programs and more counselors are needed – a theme that we return to in the recommendations section.

Other Addictions

Several participants indicated that they were currently struggling with other addictions that they considered problematic. The results reveal much about what clinicians call "co-morbidity." Interestingly, chemical and behavioral addictions measured at follow-up appeared to be dramatically reduced when compared with those who presented with these problems at intake. For instance, of the 11 clients in this sample who reported alcohol abuse problems prior to treatment, only 5 indicated that they still had problems. Of the 23 participants who reported having problems with smoking/nicotine prior to treatment, only 10 indicated that they still had problems.

The data on the so-called "behavioral addictions" were just as striking. Of the 8 clients reporting problems with shopping prior to treatment, only 3 indicated that they still had problems, and of the 11 who reported a food addiction, only 1 indicated that they still had this problem. This would seem to indicate that treatment for impulse control problems may serve to reduce addictions overall in this population. Perhaps learning coping mechanisms serves as a protective factor against addictive disorders. At the very least, while the number of individuals suffering from these problems is too small to make strong generalizations, these findings seem to indicate that the state gets significant bang for its gambling addiction buck – in that problems that extend beyond gambling addiction may well be addressed.

Gambling Behaviors

Next, interviewers asked respondents about their gambling behaviors – both during and after treatment. On this item, 29% admitted to gambling during treatment (of this population, roughly 3 out of 4 gambled 5 times or less). A similar proportion (27%) admitted to gambling since they completed treatment, though roughly half of those individuals indicated that they did not gamble for several months after receiving treatment. Overall, just under a third of participants admitted gambling during treatment or since completing treatment, indicating that recidivism is relatively low for those participating in this follow-up study.

The final section of the questionnaire examined the current gambling behaviors of those who had engaged these treatment programs. In interpreting these data, we should keep in mind that for gamblers, recall of time and money is notoriously poor (Blaszczynski et al. 1997), but we felt it important to ask specific questions about reduction in gambling behaviors, as recommended by the Banff Consensus article.

Only 15 individuals in the sample indicated that they currently gamble, and of those, most (60%) indicate that they gamble once per week or less. None indicated that they gambled more than 4 times per week.

More strikingly, 91% of respondents report reducing their gambling frequency since participating in treatment. Furthermore, most of these reductions are dramatic, with a very strong majority (64%) of those reporting reductions indicating that they reduced their gambling by 5-7 days per week. Meanwhile, another 31% of those reporting reductions said that they reduced their gambling by 2-4 days per week, meaning that 95% of this group reduced their gambling by at least 2 days/week.

Interviewers also asked about reduction in gambling habits in terms of hours per gambling episode (for instance, an individual who used to gamble 4 hours per episode and currently gambled 1 hour per episode had experienced a reduction of 3 hours per

episode). Here, results were once again dramatic: of those reporting a reduction in gambling duration, 10% reported reducing their gambling by up to 1 hour/episode, 51% reported reducing their gambling by up to 5 hours/episode, 25% reported reducing their gambling by up to 10 hours/episode, and 14% reported reducing their gambling by over 10 hours/episode.

The final measure of reduction of gambling behaviors focused upon the amount of money lost per gambling episode (to illustrate, a gambler who reduced their gambling losses from $100/episode to $20/episode would see an $80/episode reduction). Once again respondents reported sizable reductions: 3% reported reducing spending by up to $20/episode, 3% reported up to $50/episode, 12% reported up to $100/episode, 58% by up to $500/episode, and 23% by over $500/episode.

When asked specifically about abstinence, 66% of the sample identified themselves as being currently abstinent from gambling. Of those reporting abstinence, 89% report being abstinent for a month or longer, and 44% report abstaining for 6 months or more (recall that these clients may have completed treatment recently, and hence have not had time to accumulate abstinence).

In sum, the frequency and duration of gambling among this sample appears to have been significantly reduced; additionally, the amount of money spent on gambling activities was also significantly reduced. These findings are quite encouraging in light of the research literature's suggestions to measure reductions in gambling behavior. Some reductions were quite dramatic, and perhaps reflect the instability of participants prior to their participation in treatment. Whatever the case, for the vast majority of individuals who participated in this study, it appears that their current gambling activity bears little resemblance to that which took place when they were playing problematically.

QUALITATIVE RESEARCH

After posing a series of quantitative questions, interviewers also asked for qualitative input from each of the respondents. This qualitative approach allows respondents to express their thoughts in their own words, rather than in categories predetermined by the research team. All responses were recorded verbatim and then coded by the members of the research team, which then convened to develop a final coding scheme for the qualitative data. This section summarizes the main themes that emerged from the research team's coding efforts. As frequently as possible, we attempted to allow the respondents' exact words to "speak" without much editing or condensing. Furthermore, except for rare cases in which comments echoed precisely other comments, all qualitative feedback is included in this section.

In this section, we start by examining respondents' overall evaluations of these programs, and proceed to exploring the changes in the life course that interviewees described. We then turn our attention to specific features of the programs that were referenced (including the therapists, the educational offerings, the social aspects of the treatment setting, and the focus on personal responsibility and control). Next, we focus specifically on family impacts, as articulated by collateral reports from loved ones. Finally, we conclude with a summary of the shortcomings and recommendations that clients listed.

Overall Evaluations

Interviewers were struck by the degree to which these clients were enthusiastic about sharing their insights and ensuring that their voices were heard. This enthusiasm is no doubt reflected in the excellent response rate that was achieved even in the face of tight research deadlines. Two respondents expressed their gratitude for the opportunity to participate both in treatment and in follow-up research thusly:

"Actually, I really appreciate the opportunity to provide feedback and to have participated in the program. It was very helpful. (The therapists) -- they both were fabulous, very personable, and made it easy to attend the entire classes and groups. If anybody else would like to contact me about the program to hear about how great it was, I'd be totally willing -- they helped me and I'll help them."

"I highly recommend it and I'm happy to talk about it. It is a very, very good program and I'd recommend it to anybody. You have very, very good instructors. If anybody had a problem and needed help, I'd definitely recommend them -- they're very good.

"I really appreciate all of the people who are working so hard to help problem gamblers - I really appreciate the work that you are doing to learn more about us and how to help us -- we really really need it."

Other respondents made more general statements about the quality of the treatment that they received.

"Great program. I am so thankful they were there for me."

"They brought a lot of light into my life and into my thinking. They help you find yourself. They are there for you, and they are always there in my heart. Now, when I feel itchy I go to them."

"I liked the treatment. I'd recommend it to anybody."

"I think the program is superb."

"It's an excellent program. I really recommend it and realize it's a real positive."

We were particularly impressed with the "pay it forward" nature of this response:

"I'm so happy with the treatment, I went back to see some of my fellow former gamblers move on in program. I provided (the program) with a scholarship to others so they can continue in the program, so that is a statement of how I feel."

While this respondent clearly had the financial means (at least post-treatment) to provide others with scholarships, far more common were stories of financial ruin. Many mentioned that the affordability of treatment was vital, and that they could not have participated had they been charged a significant amount of money. Some respondents, very much aware that these programs were made possible by state funding, chose to speak directly to their importance to Nevadans.

"I was desperate financially so I couldn't afford private therapy -- but this was as close to finding private therapy as I could get. I was looking for something I could afford and that would keep my life private. They really need these kinds of places desperately. I've lived here since '91, and the people who ruin their lives ... (trails off) And it's not just happening here, but here it's worse because it's everywhere. I just really appreciated them."

"I think it's a great opportunity to give the people of Nevada an opportunity to get themselves straight, to see what they're doing to themselves and their families. I think it's a great great program and there are so many people out there who are losing the family life, their homes, their savings. They really need to do something about it -- if they have a program, people can turn their lives around."

"Nevada really should fund this."

"Especially in this state where gambling is so prevalent -- I mean, it's not an excuse, we're all grownups and make our own choices -- but it really feeds into people's addictions, and I think we need to do this. The state spends so much money to keep our state's big industry going, and they should also spend money on its people, especially those whose lives go down the tubes. I think it is the responsible thing to do. People really get a lot out of these programs and it really does save a lot of lives."

"I really am grateful it is available. It is the best thing that could happen in this state. I was blessed to use it."

"I think that these programs need a lot of support. My husband was talking about leaving me because of my problem, and (the program) helped me to the point where I don't gamble anymore and it now saved my marriage. Hopefully they'll keep supporting this so that they can help more people like me."

"I think it's so important -- this program with the grant was so affordable, it saved my life."

In the next section, we examine more closely the point made by this last interviewee – that the life changes experienced by many were profound and powerful.

Changes in the Life Course

Clients often marveled at the changes that had taken place in their lives since they began these programs. A striking number of individuals claimed that these programs were life-saving in nature:

"It just saved my life. It was totally effective for me."

"It's a program where you can just be open for the first time and it saves your life."

"I most definitely highly recommend (this program). It has saved my life."

"The (program) has truly saved my life. They provided a program that worked for me."

"I feel like it saved my life. I gambled for 30 years."

"I think it was wonderful, intense… I don't understand how they did it, but they made it click. You knew you didn't want to gamble. They saved my life."

"It saved my life. Excellent program. Intense, covered all the bases and it really helped."

"The treatment saved my life, I tried to kill myself, and right after I immediately went to treatment. It was fantastic. My daughter went with me, when she went in she realized that she had the same problem. She took the course too and we both have been gambling free for a while now."

"To me (this program) is a necessity because it saved my life. I tried other things, I was embarrassed to go back to GA. This program was my last resort. I'd strongly advise it to anyone with a problem."

Others shared comments that revealed the depths of the changes that they had seen in their own lives:

"It changed my life. The program is absolutely life changing. I have gambled for 27 years and could not quit -- the last 10 years were really bad. For the first time, I feel I am out of that vortex. I was spinning in it. I thought about gambling 24 hours a day, but I don't have that anymore."

"My life is definitely much improved as a result of this program."

"They woke us up -- we should have known better, but we didn't. Yes, it really helped us, it woke us up, and what also helped is to find out that I'm not the only one who does dumb things like this. I don't even miss the casino. When I think back to how foolish I was, that wasn't very bright, and I should be -- I went to enough schools! Nobody taught us in college not to gamble like this, though. I'm very thankful that this organization helped us."

"Best thing I've ever done in my life."

"If it wasn't for the (program) I'd still be out there."

"My life has really changed for the better."

"The treatment I think is great, without it I would not have stopped."

"The best thing that has ever happened to me. I can't say enough good things about it."

Specific Features – Therapists

When speaking of the strengths of these programs, many cited the therapists themselves. In fact, as we will see later, even those who had structural complaints about these programs tended to compliment those who ran them.

"I think (the therapists) are wonderful, caring. Both (of the therapists) are great."

"(The therapist) is awesome -- she's so great."

"The two therapists were outstanding, really supportive, helped me figure out really what my main problems were, which is a major factor."

"I have a high regard for the counselors there, especially (name)."

"(The therapist) was very caring -- she actually cared and tried to help out as much as she could."

"(The therapist) was very knowledgeable and smart. I learned a lot and definitely recommend the program. It was successful."

"(The therapist) is a very very wonderful lady. She made me see (my) gambling as it was -- an addiction. I'm very very thankful to her."

"It's a really good program. I feel fortunate that I got to participate. (The therapist) does a wonderful job and is so knowledgeable. The counselors were sympathetic, empathetic, and compassionate. I couldn't ask for a better group of people."

"I love (the therapist), she's helped me tremendously. Like I said, I would recommend her to anybody -- in fact, I've been trying to get my brother to go. Just being able to talk openly and not feel like I was being judged -- because a lot of people were judging me. I get a hug every time I go in, and it's really helped to get it out in the open, to finally get to talk to

somebody about it. Living in Vegas is not the easiest thing in the world, and this has really helped."

"I just think it was very good, I think that the people were associated with it were especially nice and understanding, I loved (the therapist), the people were very good. I think that it's a good program, run by good people. They work really hard to help you."

Specific Features – Education

Other participants found the educational aspects of treatment to be particularly beneficial. This finding highlights the importance – often cited in the treatment literature – of educating clients about the cognitive distortions that are common among problem gamblers. This "education on thinking" was articulately described by one respondent, who made thoughtful connections between the shifts in thinking that took place and the self-control that resulted:

"It's very informational, it gives you information and it makes you realize how irrationally you are thinking when you're gambling -- because you're really not thinking. You're also not feeling, and you get your feelings back, you deal with your emotions, you deal with life's problems, you can deal with anything, and they teach you to do that on your own."

Some had more general comments about the value of the information offered in these settings, and one respondent extended this appreciation to the family level:

"The quality of info you get you do not get anywhere else. You get an educational background."

"What I really loved about it was that it was educational for my family. That was huge in getting me to stop."

It is important to point out here that in praising the value of educational components of professional treatment, respondents did not dismiss the knowledge of peers and/or 12-step groups – in fact, several claimed that professional treatment and Gamblers Anonymous were complementary.

> *"I thought it was excellent, they gave a lot of feedback and information. Anyone I know (who has a gambling problem) I would say go to it and GA, which was also an important part."*

> *"The program really helped me to see other points of view from other gamblers, and it brought me a lot of awareness I did not have."*

This last quote reflects the importance of connecting socially with other gamblers, a theme that we explore more thoroughly in the next section.

Specific Features – Social Aspects

Several respondents spoke eloquently about the social aspects of the treatment setting, and highlighted the bonds that were developed with both peers and mental health professionals.

> *"I tried on my own, and couldn't (stop gambling). Walking in there, it felt like someone cared."*

> *"I got to know the people within the program really well. I had never followed a program like this one. I feel really good about what I have done."*

> *"At first I was apprehensive, I didn't know why I was there. I had been gambling with my husband for 30 years. After going through it, and*

attending the meetings, a particular thing happened to me. I saw a person get totally crushed, his reputation, because of gambling. The good thing is that they have the (program), they can go in and find out what is wrong. You gotta get a handle on it. They need this badly, we are not bad people -- we just have a bad habit. I strongly support it."

Specific Features – Personal Responsibility and Control

For many respondents, personal responsibility and re-establishing control over behaviors and impulses were key themes – a finding supported by the quantitative data as well:

"I'd say that this program is very helpful. It helped me to regain control of my life and to stop gambling… The staff is very understanding and very helpful, and yet very firm -- I like that they're firm, because they do it to help you. They're very straightforward and no beating around the bush."

"I actually went in with the attitude that it wouldn't happen, but it did! It shocked me that it worked. I thought I was beyond help. They made you feel like you had the control. No guilt. It was great."

"The people that work there, they are good, they direct people in the right direction, no excuses accepted."

"The program is wonderful and it really helps you stop gambling. But gambling is not the problem, I am the problem -- and it helps you solve them."

Family

While time constraints imposed by the legislative calendar did not permit us to conduct interviews with "collaterals" (friends and family of clients), on a few occasions family members actually demanded the phone after we conducted the interview with a client, and interviewers dutifully recorded their thoughts.

Of course, these spontaneous evaluations should not be interpreted as scientific (or even systematically collected) data, but we did think it would be informative to share two stories in particular. Notably, both stories in a sense reflect "uniquely Nevada" tales, in that these families worked in two of the primary sectors of the state's economy: the military and the gaming industry.

In one instance, the wife of a retired Air Force officer described at length the positive impact that these programs have had on her family:

> *"We've been married for 33 years, and people in this state need to understand how important this (program) is. I can tell you what occurred within the family, and I can say that I am a woman of faith, and had it not been for that, this family might have blown apart. I look at the whole sphere of addictions, and they really are all the same. Gambling is marketed heavily here, and there are people who will succumb. We moved here from (a nearby state), and the gambling started 6 months later. Prior to this time, he would gamble, and I knew nothing about it, and he gambled what he could afford to lose. But something occurred somewhere, and my husband turned into... he went to the dark side! Basically, we had model credit, never had any kinds of problems, and that turned into a way to destroy himself because he could go anywhere and they'd give him $10,000. By the time he was discovered -- he was quite astute in hiding this, and went to the point of secret bank accounts, PO boxes, and at some point he went off the deep end. He was quite successful in hiding what was happening to him. Our last child was going through school and I was very involved in the school, adapting to his*

teenage years, etc. (My husband) was found out only by a credit card company who happened to call me, and it was a credit card that hadn't been used in 10-15 years, and to me didn't exist anymore. It was at that time that I realized that the credit card accounts were never fully closed. He proceeded to destroy himself. He ran up a quarter of a million dollars worth of gambling debt -- and we're not super-wealthy. He gambled away the farm. (This) program -- once he found it and went, he stopped gambling. He began to deal with reality, and basically discovered what a horrible situation this is. What's improved is that when we went to (the program), it was basically with the idea of how do we handle or are we going to handle this problem, and also with (him) coming to terms with it. His personality began to grow and mature -- he's a retired air force officer, went to Vietnam, fought for his country, and was so mature professionally -- but at the same time there were parts of him that were what I consider childlike. After the program, I saw him grow into manhood. It's an odd thing, he was maturing in certain areas, and the program really helped in that way. It's an experience I would wish on no one -- but there has to be recognition that these kinds of things happen, and yes, drugs and alcohol can beat you up, but gambling can really destroy things in terms of the financial picture. Somewhere along the line, there has to be someplace where people can turn for help. What I've got today is a whole man. Before, he had many "holes of immaturity" I used to call them -- now he is whole. Now, I am living with an adult man, not a man who was partially adult. I am just so glad that Nevada is paying attention to this. To me it's a dirty little secret, and it should not be, because there are so many people like me who are going through this. I met so many people whose families were falling apart, and like us, they all need the help that is provided by this."

Her husband described his perspective on the experience in this way:

"I retired as an Air Force officer here in (a recent year). When I first hit the brick wall and realized I had lost $230,000 I didn't have, after the shock of it all hit me and my family, at first we went to GA, and then we went to a church recovery group, and then came across this program, so I hooked in there. Through the sessions with (the therapist) and my wife, we really started to uncover different things that led to the compulsive gambling and went from there. Now, actually, I'm going to go back -- I sure hope the funding remains because I still have work to do. I am a Vietnam vet and had long suspected that I had PTSD, and through the sessions, I've really come to learn about factors like that that were causative. I fully believe that this program is beneficial, and I know many people feel the same way. (This program) really helped me put my family back together."

Another spouse happened to work in the gaming industry, and felt that he had a unique perspective on these problems – and their solutions:

"The impact so far has been great -- this is a fantastic program. I'm a table games supervisor at the (name of casino), and last year (his wife) cost us $25,000, and we don't have that kind of money. Having seen the program in action, a lot of my guests I'd like to send over to these programs, I can tell you. It's definitely very desperately needed in this town -- and I work in the industry, so I'm not opposed to gambling -- but there are so many people I see every day who are devastated and need help."

Shortcomings and Recommendations

As evidenced by both the quantitative and the qualitative findings, only a small handful of individuals had negative impressions overall, but those who were critical offered important information that might be used to improve the services offered in these programs. We should note, however, that most of the negative comments that follow were shared by those who had a positive impression overall.

Furthermore, many of the clients' comments about shortcomings in these programs actually point to structural issues that might be better addressed with additional funding or a redistribution of funds. For instance, many clients expressed strong concerns that there was "not enough treatment." These concerns usually pertained to the lack of a variety of meeting times, a lack of additional programs, a lack of more help for the family, or a lack of one-on-one programs. Others remarked that enhanced accessibility or more treatment locations would have helped.

To illustrate, some respondents who had gambling "slips" remarked that geography played a role in their fall. Others had comments that requested more diverse offerings that reflected the needs of a diverse slice of the problem gambling population, noting that a one-size-fits-all model cannot address all of the needs of all of these populations. One individual spoke movingly about accessibility issues, indicating that she could no longer attend treatment after her car broke down and she couldn't afford to fix it. *"I'd like to go back,"* she said. In the future, transportation assistance programs might help financially destitute individuals do precisely that.

Overall, by far the problem most frequently cited by these interviewees was that they wished to see more programs and more clinics available to problem gamblers and their families.

> *"I couldn't continue going because we moved from that area to the other side of town to North Las Vegas, and the drive now is about 45 minutes, but I really wish I could continue going, and I wish it was close by so I could do it because I do not have any support, and truly GA is a different thing. Over there (at the treatment facility), it was a really small group,*

and we all got to know each other, and checked on each other. I really do miss it and hope to find a program around this area."

"I liked everything about it, and I'm sure if I would have continued, I would have done better. But I didn't continue. I stopped going. It was too far out from where I lived."

"I wish that they would have many many more sessions and flexibility so that people could go with their schedule, you know."

"They need to do more of this, and they need to offer them at more times -- I had to rearrange my schedule, and if they supported them more they could offer more programs. It was a real time crunch for me, and it would have been better at different times. This is a 24 hour town, people work at all hours, so there should be more programs to provide more flexibility."

"The positives were that they were very comfortable to talk with, I didn't feel uncomfortable at all, with my wife being there it was really really important to me for her to see what I was going through. The only downsides were that there were waiting lists, and not enough hours, not enough time to see (my wife) get more out of it. That's the only negative, and it's not really a negative."

"The only limitation we have is time, and it's tough to get to the meetings. I've got a 2 year old and a 4 year old to take care of, and the time flexibility is difficult, so they should provide more flexibility."

"Very professional and helpful. Overall it was good experience and I would recommend it. It needs to be for a longer period of time -- 6 weeks is just not long enough for some people."

"They need more offerings for more kinds of people."

"It's not perfect, but it is the best available program for real problem gamblers. I've tried GA for 2 years to stop… Only thing I wish they would provide is a pressure release group, when you are so emotionally distraught you can come in and immediately deal with that problem. They don't deal with immediate pressures."

Some complained that these programs could benefit from enhanced public awareness, and one respondent pointed out that she discovered the program almost by accident:

"It should be known more to people with gambling problems. It was a fluky chance that I got a card from a lady about (the program)."

Others expressed concerns that Ph.D. psychologists were not as involved – which again may reflect a structural shortcoming. While state funding also went into training more counselors in Nevada so that they might treat problem gamblers, some felt that these changes could not come quickly enough.

"Counselors should have been psychologists."

Another participant echoed this concern with a lack of experience, and also expressed concern about the lack of a diverse range of programs:

"They need more experience. When I had some of my own answers it was as if I was telling them what to do. I finished it, and feel that just in finishing it, just seeing what help is available is important. They also need help for those that have not lost their house. Treatment should also be geared to a level where everyone can receive benefits -- not just for those that have lost everything."

Even the client who was by far the harshest critic – she felt that the counselors were too hard on clients -- concluded with kind words about the overall experience:

> *"I thought the counselors, for being a premier center, were not skilled. One was extremely harsh and abrasive. It seems that with people that are vulnerable, that is not the right approach, it has turned others off to the treatment. On the good side, it is definitely good that it is there. I feel I am better for going through it."*

In many cases, those who did not experience positive outcomes placed blame upon themselves rather than the programs. These respondents had things like this to say about the entire process:

> *"I really think that the program was incredible and they need to support it in any way that they can. I was doing much better when I was seeing (the therapist), I don't want them to think that she didn't help me because she really did."*

> *"I thought (the program) was very good. I felt that if I had put my mind to what she suggested and advised I would not be gambling."*

> *"I think absolutely these are great programs, I think for me personally, I've made some bad choices but when I was going every night and sitting with the group, I got a lot out of it, and they're very caring people and it's a great program and it really did help me a lot."*

> *"It was difficult for me because it wasn't geared for me. I am bipolar in a serious way, with PTSD, so it's hard to distinguish the gambling from that. But of course the state should support these-- they should do more.*

So much of the population is made up of gamblers, they're so far short, they just don't have enough help out there."

"I think all their tools are great. I should have stayed in longer."

Finally, one respondent who had experienced a painful relapse indicated that the telephone interview inspired him to return to the treatment setting.

"I really liked the program. I am gambling now, but it's not their fault. I think it's very necessary, I just wish I had more gumption and guts to follow it. I was very happy, in fact (the therapist) was very good, she helped me, but it was just I can't control it myself. I still can't control it. I'd like to get back into the program. I've been meaning to call her, and now that I've talked with you, you know, I will call her."

CONCLUSIONS AND RECOMMENDATIONS

- Clearly, both the quantitative and the qualitative analyses indicate that interviewees were very pleased with the treatment that they received. The overwhelming majority reported very positive quantitative impressions of the programs, and this finding was reinforced by the exceedingly positive qualitative evaluations of their experiences. In addition to these attitudinal measures, behavioral measures indicate that these individuals experienced profound improvements in these areas as well.

- These findings are perhaps especially impressive when viewed in light of the fact that those who seek treatment tend to be the severest of problem gamblers. Furthermore, this study examined both completers and non-completers of treatment, which seems to indicate that even partial interventions can yield significant improvements in the wellbeing of those seeking treatment.

- More concretely, very strong majorities felt that they were able to get all of the services they needed, that they were encouraged to take responsibility for their life, and that they were given the information they needed to take charge of their gambling problem.

- When asked their opinions about the direct results of the services they received, respondents indicated overwhelmingly that their lives had changed for the better. This finding was consistent in both the quantitative and the qualitative analyses conducted for this study.

- Specifically, very strong majorities indicated that as a direct result of the services they received, they dealt more effectively with daily problems, they were better able to control their lives, they dealt more effectively with crises, they got along better with their families, they did better in social situations, they did better in

school and/or work, their housing situation had improved, their symptoms were no longer as bothersome, their financial situation improved, they spent less time thinking about gambling, and they had re-established important relationships in their lives. Clearly, respondents felt that these programs had profound and powerful effects on their material, emotional, social, and psychological wellbeing.

- Interestingly, chemical and behavioral addictions were also dramatically reduced among many who participated in the survey. This finding suggests that the mental health improvements observed extend beyond the narrow range of problems associated with gambling, and that these services may well help address the complex constellation of addictive issues that face individuals with gambling problems.

- About one-third of participants admitted to gambling during treatment or since completing treatment, indicating that recidivism is relatively low for those participating in this follow-up evaluation. Furthermore, the qualitative research conducted for this report revealed that virtually all of those who had "slipped" tended to blame themselves and not the treatment process.

- Overall, respondents reported substantial reductions in their gambling – measured both in terms of time played and money spent while gambling. A very strong majority indicated that they were currently abstinent from gambling, with a large number reporting that they had abstained from gambling for six months or longer. As the research literature suggests that abstinence is a strong measure of success, it would seem that this finding provides additional evidence of the positive effects of these programs.

- When asked about additional services that might enhance the treatment experience for problem gamblers and their families, respondents suggested legal assistance (including bankruptcy advice), loan and debt programs, aftercare counseling programs (for gambling and for other needs), and one-on-one

counseling. Ultimately, the biggest criticism articulated in both the quantitative and qualitative analyses was that respondents indicated that they wanted more services. Notably, with additional funding and/or a redistribution of funds, these needs can be better addressed in the future.

- Many also suggested that further improving upon the skills of treatment providers would be welcome. Hence, in order to provide more and better treatment for the state's problem gamblers, we recommend that the state continues its commitment to educating those who help problem gamblers and their families. This means supporting educational programs and workforce development for clinicians who encounter problem gamblers in their practices.

- As our understanding of the complexities of problem gamblers evolves and grows ever more nuanced, it makes less and less sense to apply a one-size-fits-all treatment model to all problem gamblers in Nevada – or anywhere else, for that matter. Increasing evidence is emerging to suggest that problem gamblers are a heterogeneous group that might benefit from treatment approaches that cater more to their diverse needs. As many have noted, a single conceptual model may well neglect the varied characteristics that problem gamblers possess and present when showing up for treatment (Blaszczynski, 1999; Gonzalez-Ibanez et al., 2005; Toneatto, 2005). Looking forward, in an overview on the state of pathological gambling treatment, Potenza (2005) anticipates that "algorithms matching specific groups of pathological gamblers with specific treatments will be developed" – a development that this research team would also welcome. Hence, in much the same way that not all heart patients are treated with the same tools, nor should problem gamblers all be placed beneath the same treatment umbrella.

- Finally, we also recommend more generally that the state continue its commitments to the state's problem gamblers and their families, and that it continues to conduct independent research on the efficacy of these commitments.

APPENDIX A: Problem Gambling Program Evaluation Survey

In order to provide the best possible problem gambling services, we need to know what you think about the services you received.

Please indicate your agreement/ disagreement with each of the following statements by circling the number that best represents your opinion.	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
1. I like the services that I received from this service provider.	1	2	3	4	5	9
2. I would recommend this agency to a friend or family member.	1	2	3	4	5	9
3. Services were available at times that were good for me.	1	2	3	4	5	9
4. I was able to get all the services I thought I needed.	1	2	3	4	5	9
5. Staff here believe that I can grow, change and recover.	1	2	3	4	5	9
6. I felt comfortable asking questions about my treatment.	1	2	3	4	5	9
7. Staff encouraged me to take responsibility for how I live my life.	1	2	3	4	5	9
8. Staff were sensitive to my cultural background (race, religion, language, etc.)	1	2	3	4	5	9
9. Staff helped me obtain the information I needed so that I could take charge of managing my gambling problem.	1	2	3	4	5	9
10. I was encouraged to use other appropriate programs (support groups, 12-step groups, crisis phone line, etc.).	1	2	3	4	5	9

In order to provide the best possible problem gambling services, we need to know what you think about the services you received and the results.						
	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
As a Direct Result of Services I received:						
1. I deal more effectively with daily problems.	1	2	3	4	5	9
2. I am better able to control my life.	1	2	3	4	5	9
3. I am better able to deal with crisis.	1	2	3	4	5	9
4. I am getting along better with my family.	1	2	3	4	5	9
5. I do better in social situations.	1	2	3	4	5	9
6. I do better in school and/or work.	1	2	3	4	5	9
7. My housing situation has improved.	1	2	3	4	5	9
8. My symptoms are not bothering me as much.	1	2	3	4	5	9
9. My financial situation has improved.	1	2	3	4	5	9
10. I spend less time thinking about gambling.	1	2	3	4	5	9
11. I have re-established important relationships in my life.	1	2	3	4	5	9

We are now going to ask you a few more general questions about the treatment you have received.

Since the time you began the problem gambling program, have you used the services of any other programs?

1 = Alternative Health Care (Home health aides and homemaker services)
2 = Financial aid for housing
3 = General Assistance Temporary Employment Program
4 = Transportation Assistance
5 = Homeless Assistance
6 = Long Term Care
7 = Medical Care
8 = Counseling
9 = Senior Citizens Protective Care
10 = Veteran's Assistance
11 = Welfare
12 = Other (including GA, other 12-step programs)

Were there any services that were not provided by the problem gambling treatment program that you would have liked to see provided? (ENTER OPEN-ENDED RESPONSE)

Are there other addictions that are currently problematic for you?

YES NO

IF YES:

Is this addiction behavioral or chemical?

We are now going to ask you a few questions about your gambling behaviors. Remember that all of your answers are completely confidential, and that you may refuse to answer any questions or withdraw your participation at any time.

1. **While you were actively participating in the treatment program, did you gamble at all?**

YES NO

IF YES: How many times did you gamble while in the treatment program? (RECORD NUMBER)

2. **Since you completed the treatment program, have you gambled at all?**

IF NO: Skip this section, proceed to "Abstinence" section.

IF YES: a. What kind of gambling game did you participate in?

1 = Table – Cards
2 = Table – Roulette
3 = Table – Craps
4 = Keno
5 = Slot Machine
6 = Video Poker
7 = Sports Book
8 = Bingo
9 = Other

b. After completing the treatment program, when did you first gamble?
(ENTER DATE)

c. Currently, how frequently do you gamble?

- Number of days per week

d. Currently, how long is each gambling episode on average?

- Hours per episode

e. Currently, how much did you gamble during each gambling episode on average?

- Estimated amount of money gambled per episode

IF NO: Abstinence

a. As of today, how long have you been abstinent from gambling?

- Length of time abstinent from gambling; specify units of time

ALL RESPONDENTS

1. Thinking back to the period of time when you gambled most heavily, have you reduced your gambling since this time?

IF YES:

a. How many days per week would you say you have reduced your gambling?

- Number of days per week (e.g., before = 5 days/wk; now = 2 days/wk, so reduction is 3 days/wk)

b. How much have you reduced your gambling in terms of hours per gambling episode?

- Estimated hours per episode (e.g., before = 5 hrs/episode; now = 2 hrs/episode, so reduction is 3 hrs/episode)

c. How much have you reduced your gambling in terms of the amount of money that you spend per gambling episode?

- Estimated amount of money (e.g., "I used to spend $100/night and now I don't gamble at all"; therefore reduction is $100/night)

QUALITATIVE SECTION

Finally, we would like to provide you with the opportunity to add any comments that you may have about the treatment that you received (RECORD QUALITATIVE RESPONSES VERBATIM).

REFERENCES

APA. (2000). Diagnostic and Statistical Manual of Mental Disorders DSM-IV-TR, American Psychiatric Association Task Force on DSM-IV, 4th ed. Washington, DC: American Psychiatric Association, 2000.

Bernhard, B. (forthcoming). On the shoulders of Mills: A clinical sociological imagination via a bio-psycho-social-sociological model. *American Behavioral Scientist.*

Blaszczynski, A. (1999). Is pathological gambling an impulse control, addictive, or obsessive compulsive disorder? *Annuario de Psycologia,* Universidad de Barcelona.

Blaszczynski, A. (2005) Conceptual and methodological issues in treatment outcome research. *Journal of Gambling Studies* 21, 5-11.

Blaszczynski, A.P., Dulao, V. & Lange, M. (1997) 'How much do you spend gambling?'. Ambiguities in survey questionnaire items. *Journal of Gambling Studies*, 13, 237-252.

Echeburúa, E., & Báez, C. (1994). *Tratamiento psicológico del juego patológico*. In J. L. Graña (Ed.), Conductas adictivas: Teoría, evaluación y tratamiento. Madrid: Pirámide.

Echeburúa, E., Báez, C., & Fernández-Montalvo, J. (1996). Comparative effectiveness of three therapeutic modalities in the psychological treatment of pathological gambling: Long-term outcome. *Behavioural and Cognitive Psychotherapy*, 24, 51–72.

Echeburúa, E., & Fernández-Montalvo, J. (2005). Psychological Treatment of Slot-Machine Pathological Gambling: New Perspectives. *Journal of Gambling Studies*, 21, 21-26.

El-Guebaly, N. (2005) Pathological gambling, comorbidities and treatment outcome: is the bronze standard enough? *Journal of Gambling Studies*, 21, 43-49.

Gonzalez-Ibanez, A., Rosel, R., & Moreno, I. (2005) Evaluation and treatment of pathological gambling. *Journal of Gambling Studies*, 21, 35-42.

Hodgins, D.C. (2005) Implications of a brief intervention trial for problem gambling for future outcome research. *Journal of Gambling Studies* 21, 13-19.

Hodgins, D.C., & Makarchuk, K. (2003). Trusting problem gamblers: Reliability and validity of self-reported gambling behavior. *Psychology of Addictive Behaviors*, 17, 244-248.

Hollander, E., Sood, E., Pallanti, S., Baldini-Rossi, N., & Baker, B. (2005). Pharmacological treatments of pathological gambling. *Journal of Gambling Studies*, 21, 101-110.

Klingemann, H., Sobell, L., Barker, J., Blomqvist, J., Cloud, W., Ellingstad, T. et al. (2001). *Promoting self-change from problem substance use. Practical implications for policy, prevention, and treatment.* Dordrecht, The Netherlands: Kluwer.

Korn, D.A. & Shaffer, H. (1999). Gambling and the health of the public: Adopting a public health perspective. *Journal of Gambling Studies, 15*(4), 289-365.

Ladouceur, R. & Shaffer, H.J. (2005) Treating problem gamblers: working towards empirically supported treatment. *Journal of Gambling Studies*, 21, 1-4.

Nathan, P. (2005). Methodological problems in research on treatments for pathological gambling. *Journal of Gambling Studies*, 21, 111-116.

National Research Council (1999). *Pathological gambling: A critical review.* Washington, DC: National Academy Press.

Petry, N. (2005). Gamblers Anonymous and Cognitive-Behavioral Therapies for Pathological Gamblers. *Journal of Gambling Studies*, 21, 27-33.

Potenza, M. (2005). Advancing treatment strategies for pathological gambling. *Journal of Gambling Studies*, 21, 93-100.

Shaffer, H.J., Hall, M.N., & Vander Bilt, J. (1999). Estimating the prevalence of disordered gambling behavior in the United States and Canada: a research synthesis. *American Journal of Public Health*, 89, 1369-1376.

Shaffer, H.J., LaBrie, R.A., LaPlante, D.A., Kidman, R.C., & Donato, A.N. (2005) The Iowa gambling treatment program: treatment outcomes for a follow-up sample. *Journal of Gambling Studies*, 21, 61-73.

Toneatto, T. (2005). A perspective on problem gambling treatment: issues and challenges. *Journal of Gambling Studies*, 21, 75-80.

Volberg, R.A. (2001). *When the chips are down: Problem gambling in America*. New York, NY: The Century Foundation.

Volberg, R.A. (2002). *Gambling and Problem Gambling in Nevada.* Report to the Nevada Department of Human Resources. Carson City, NV: Department of Human Resources. Available at http://www.hr.state.nv.us/.

Walker, M. (2005). Problems in measuring the effectiveness of cognitive therapy for pathological gambling. *Journal of Gambling Studies*, 21, 81-92.

Walker, M., Toneatto, T., Potenza, M., Petry, N., Ladouceur, R., Hodgins, D.C., el-Guebaly, N., Echeburua, E., & Blaszczynski, A. (2006). A framework for reporting outcomes in problem gambling treatment research: the Banff, Alberta consensus. *Addiction,* 101, 504-511.